HB 173- Testimony for Michele Sare, MSN, RN
Lead Public Health Official for Granite County 3/30/2009

Thank you Chairman Brown and Members of the Senate Public Health, Welfare and Safety Committee for this opportunity to testify in favor of HB 173 – Appropriation for rural Montana healthcare delivery assistance pilot project. This bill is meant to assure for a sustainable model of Public Health (PH) for all of Montana. I am speaking to you as a frontier county Lead Public Health Official (which translates to 'the only one').

First, I would like to recognize and thank Representatives Hendrick and Villa. It has truly been an honor and a pleasure to work with these two community advocates – who personify 'representation'. They took the time to listen, to learn and to create a solution for the problems that we brought to them. Honestly, they have renewed my faith in the political process – thank you Representatives Hendrick and Villa for getting us this far – it's been an amazing journey and a tremendous blessing.

"According to McKinsey & Co. as of 2008, the average Fortune 500 Company will spend as much on health care as they make in profits'[1]. Our health care system is ranked 37th worldwide, yet we spend over 15% of our GNP on that very healthcare[2]. A cardinal solution set is glaringly obvious and has been in place since 1915[3]. Instead of constantly treating disease and injury – prevent them: "Keeping people healthier is one of the most effective ways to reduce healthcare costs"[4]. Public Health is the foundational entity that promotes health and works to prevent disease.

PH is exciting – I love PH and all that I am charged to do for my friends, neighbors and community. In my 33 years as an RN, I have spent over ten years in PH. We can impact the horrific healthcare, chasms, disparities and costs – PH knows how to keep people healthier and how to improve years and quality of life. It is an exciting and valuable profession!

When I took my current PH job 1 ½ years ago there were no policies and procedures, no forms for immunizations, home visits, employee records, how to change voice mail, cell phone passwords or any other basic business function processes. Less than six months into the job, home health pulled-out of our county and I suddenly became the 'home health' nurse in addition to my duties of running a one person show managing several different programs; immunizations, maternal child, FICMR, over-seeing respite care aids & their HV, epidemiology, home visiting for case management, CPT, flu clinics, PHEP, getting an LEPC and BOH re-started and going, B12 shots, blood pressure clinics and a myriad of other legal, individual and community health concerns. PH in my county was a mess to say the least – and not too exciting. I set out to figure-out why our county did not have any operational definitions for a functional local health department.[c] It became my mission to improve PH for our county.

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[1] Andy Stern, President of the Service Employees International Union
[2] World Health Organization
[3] Lillian Wald – the founder of modern PH
[4] Trust for America's Health

I thought that it was just our little resource challenged county and that maybe something was terribly wrong with me. I needed help. So, I called Peggy Stevens in Mineral Co. because of the similar demographics and we got talking about PH challenges and solutions; it became evident that the problem was bigger than what we could handle alone – so we contacted our Representatives – for Granite Co. – Dan Villa and for Mineral Co. Gordon Hendrick - and they willingly entered into our discussions.

We needed more information – was it just Mineral and Granite counties or did others share our dilemmas? So, Peg & I developed a questionnaire with the help of her great staff – and we called 18 of Montana's 22 frontier counties (handout: '*Quick Facts*'). I think that you'll agree that the findings were alarming. No one had an operational definition of a functional local health department and most were struggling with the same conundrums that I was.

We discovered PH heroes in our midst; nurses like Mary Nyhaus in Daniels County who serves three counties where no healthcare services would exist if not for her dedication, persistence, skill, intelligence and ability to drive hundreds of miles each week. We became more passionate than ever to find a solution, not only for our little county's dilemmas, but now also for the PH nurses and their counties whose stories so deeply touched our hearts; many of whom '*are*' PH – without their dedication, tenacity and passion for their communities, there would be no PH – and in many Montana counties – there would be no healthcare at all if it weren't for these remarkable professionals and their PH department. The grassroots effort that has become HB 173 was born as we set-out with the help of our Representatives to level the public health playing field for all Montanans.

There are three entities that encompass public health: system (such as DPHHS), governance (our BOH, MCA and ARM) and local (your community's local health departments). HB 173 is about local public health sustainability. There are a great many positive things to say about PH in Montana; we are grateful for the work of our DPHHS and the many fine professionals that support our local efforts; BOH and PH law guide our decisions, but the local PH workforce – especially in our medium, small and frontier counties – comprising 84% of Montana's counties – is struggling for survival. An aging workforce, inconsistent definitions of PH practices and poorly written or absent job descriptions, lay Commissions and BOH, and unsustainable budgets threaten the viability of Montana's local LHJ.

HB 173 addresses the need to assess the challenges facing LHJ and discover and develop ways to create a sustainable model of PH for all Montana – regardless of demographics – and to define an operational definition of a local health department. A strengthened local health department will help their constituents to have improved years and quality of life...and save money. HB 173 will help counties big and small through local projects that will put a 0.5 FTE to work, in a specific timeframe, working under specific criteria, and with clear oversight from the Public Health Improvement Task Force and the designated legislative entity.

The role of Public Health in Montana is to:

- prevent disease and injury
- promote optimal wellness and
- protect individuals, families and communities from healthcare risks

According to the *Trust for America's Health* for just $10 per person per year, public health can help Montana to realize a savings of $51,000,000 in five years[5]! We're just asking for $1.10 per person per year over the biennium to assess ways to establish a sustainable model of PH for all Montana. Please talk to your local PH workforce – they are your everyday heroes steadfastly helping to improve the safety and wellbeing of your community.

If healthcare were a house, public health would be the foundation. Please help us to build a sustainable model of local public health for all of Montana.

My sincerest thanks go to Representatives Hendrick and Villa and to all those who have worked to improve the public's health across Montana. Thank you for this opportunity and for all of the work that you do on behalf of Montanans.

Respectfully submitted by,

Michele Sare, MSN, RN – LPHO for Granite County

[5] Trust for America's Healthcare; *Prevention for a Healthier America*; 2008

National Atlas of the United States

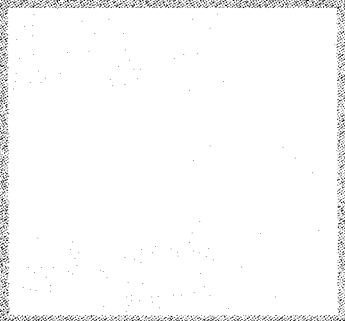
Operational Definition

of a

functional

local health

department



Public Health
Prevent. Promote. Protect.

November 2005

Governmental public health departments are responsible for creating and maintaining conditions that keep people healthy. At the local level, the governmental public health presence, or "local health department," can take many forms.[1] Furthermore, each community has a unique "public health system" comprising individuals and public and private entities that are engaged in activities that affect the public's health.

Regardless of its governance or structure, regardless of where specific authorities are vested or where particular services are delivered, everyone, no matter where they live, should reasonably expect the local health department to meet certain standards.[2]

A FUNCTIONAL LOCAL HEALTH DEPARTMENT:

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- Leads planning and response activities for public health emergencies.
- Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health significance (e.g., natural disasters).
- Implements health promotion programs.
- Engages the community to address public health issues.
- Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.
- Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.

Addresses health disparities.

Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.

Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.

Provides its expertise to others who treat or address issues of public health significance.

Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.

Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.

Facilitates research efforts, when approached by researchers, that benefit the community.

Uses and contributes to the evidence base of public health.

Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectations.

[1] For the purposes of this definition, a local health department may be locally governed, part of a region or district, be an office or an administrative unit of the state health department, or a hybrid of these.

[2] See "Local Health Department Standards," Pages 4 through 9, for further description of the functions captured in this definition.

If local health departments (LHDs),[1] as governmental entities, derive their authority and responsibility from the state and local laws that govern them. Accordingly, all LHDs exist for the common good and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; prevent illness, disease, injury, and premature death; and eliminate health disparities.[2] However, in the absence of specific, consistent standards regarding how LHDs fulfill this responsibility, the degree to which the public's health is protected and improved varies widely from community to community.

These standards describe the responsibilities that every person, regardless of where they live, should reasonably expect their LHD to fulfill. They have been developed within nationally recognized frameworks[3] and with input from public health professionals and elected officials[4] from across the country. The standards provide a framework by which LHDs are accountable to the state health department, the public they serve, and the governing bodies (e.g., local boards of health, county commissioners, and mayors) to which they report. In meeting the standards, LHDs employ strategies that are evidence-based and informed by best practices, and they operate according to the highest level of professionalism and ethics to inspire public confidence and trust.

A number of factors contribute to the variability of how LHDs operate; specifically capacity, authority, resources, and composition of the local public health system:

The LHD may have the capacity to perform all of the functions on its own; it may call upon the state to provide assistance for some functions; it may develop arrangements with other organizations in the community or with neighboring LHDs to perform some functions; or it may control the means by which other entities perform some functions.

Government agencies other than the LHD may have the authority to perform services that affect public health.

Resources for public health may be housed in a different agency.

Each LHD jurisdiction is served by its own unique public health system: public and private health care providers, businesses, community organizations, academic institutions, and media outlets that all contribute to the public's health.

As a result of these differences, how LHDs meet the standards—whether they directly provide a service, broker particular capacities, or otherwise ensure that the necessary work is being done—will vary. Regardless of its specific capacity, authority, and resources, and regardless of the particular local public health system, the LHD has a consistent responsibility to intentionally coordinate all public health activities and lead efforts to meet the standards.

The standards are a guide to the fundamental responsibilities of LHDs, allowing for varied structural characteristics of LHDs (e.g., governance, staffing patterns, size of the population served, etc.), and recognizing that each LHD may have other duties unique to meeting the public health needs of the community it serves. Several states have developed, or are in the process of developing, state-specific standards for LHDs, and the National Public Health Performance Standards Program (NPHPSP) includes standards for local public health systems. NACCHO analyses of several state initiatives and the NPHPSP have shown a high level of consistency between these efforts and NACCHO's nationally-developed standards.

Currently, not all LHDs have the capacity to meet the standards. Many concerns have been raised regarding the costs of developing the capacity, and the implications for LHDs that do not meet the standards. It is difficult to anticipate costs, and it is equally important to understand that improvements in capacity can be made in the absence of new resources. NACCHO is committed to collecting and sharing models of LHDs and LHD arrangements to demonstrate various means to enhance local governmental public health capacity. Furthermore, NACCHO is currently participating in a national dialogue on whether to establish a voluntary national accreditation system for state and local health departments,[5] and is supportive of such an effort.[6] The results of this dialogue may generate implications for LHDs not meeting the standards.

NACCHO urges LHDs to embrace these standards both as a means of working with their state health departments, communities, and governing bodies to develop a more robust governmental public health capacity, and as a means of holding themselves uniformly accountable to the public they serve.

Monitor health status and understand health issues facing the community.

Obtain and maintain data that provide information on the community's health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).

Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.

Conduct or contribute expertise to periodic community health assessments.

Integrate data with health assessment and data collection efforts conducted by others in the public health system.

Analyze data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public's health.

Protect people from health problems and health hazards.

Investigate health problems and environmental health hazards.

Prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities.

Coordinate with other governmental agencies that investigate and respond to health problems, health disparities, or environmental health hazards.

Lead public health emergency planning, exercises, and response activities in the community in accordance with the National Incident Management System, and coordinate with other local, state, and federal agencies.

Fully participate in planning, exercises, and response activities for other emergencies in the community that have public health implications, within the context of state and regional plans and in a manner consistent with the community's best public health interest.

Maintain access to laboratory and biostatistical expertise and capacity to help monitor community health status and diagnose and investigate public health problems and hazards.

Maintain policies and technology required for urgent communications and electronic data exchange.

- Give people information they need to make healthy choices.

Develop relationships with the media to convey information of public health significance, correct misinformation about public health issues, and serve as an essential resource.
Exchange information and data with individuals, community groups, other agencies, and the general public about physical, behavioral, environmental, social, economic, and other issues affecting the public's health.
Provide targeted, culturally-appropriate information to help individuals understand what decisions they can make to be healthy.
Provide health promotion programs to address identified health problems.

- Engage the community to identify and solve health problems.

Engage the local public health system in an ongoing, strategic, community-driven, comprehensive planning process to identify, prioritize, and solve public health problems; establish public health goals; and evaluate success in meeting the goals.
Promote the community's understanding of, and advocacy for, policies and activities that will improve the public's health.
Support, implement, and evaluate strategies that address public health goals in partnership with public and private organizations.
Develop partnerships to generate interest in and support for improved community health status, including new and emerging public health issues.
Inform the community, governing bodies, and elected officials about governmental public health services that are being provided, improvements being made in these services, and priority health issues not yet being adequately addressed.

- Develop public health policies and plans.

Serve as a primary resource to governing bodies and policymakers to establish and maintain public health policies, practices, and capacity based on current science and best practices.
Advocate for policies that lessen health disparities and improve physical, behavioral, environmental, social, and economic conditions in the community that affect the public's health.
Engage in UHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.

Enforce public health laws and regulations.

Review existing laws and regulations and work with governing bodies and policy-makers to update them as needed.
Understand existing laws, ordinances, and regulations that protect the public's health.
Educate individuals and organizations on the meaning, purpose, and benefit of public health laws, regulations, and ordinances and how to comply.
Monitor, and analyze over time, the compliance of regulated organizations, entities, and individuals.
Conduct enforcement activities.
Coordinate notification of violations among other governmental agencies that enforce laws and regulations that protect the public's health.

Help people receive health services.

Engage the community to identify gaps in culturally-competent, appropriate, and equitable personal health services, including preventive and health promotion services, and develop strategies to close the gaps.
Support and implement strategies to increase access to care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.
Link individuals to available, accessible personal healthcare providers (i.e., a medical home).

Maintain a competent public health workforce.

Recruit, train, develop, and retain a diverse staff.
Evaluate LHD staff members' public health competencies,[7] and address deficiencies through continuing education, training, and leadership development activities.
Provide practice- and competency-based educational experiences for the future public health workforce, and provide expertise in developing and teaching public health curricula, through partnerships with academia.
Promote the use of effective public health practices among other practitioners and agencies engaged in public health interventions.
Provide the public health workforce with adequate resources to do their jobs.

Evaluate and improve programs and interventions.

Develop evaluation efforts to assess health outcomes to the extent possible.
Apply evidence-based criteria to evaluation activities where possible.
Evaluate the effectiveness and quality of all LHD programs and

activities and use the information to improve LHD performance and community health outcomes.
Review the effectiveness of public health interventions provided by other practitioners and agencies for prevention, containment, and/or remediation of problems affecting the public's health, and provide expertise to those interventions that need improvement.

Contribute to and apply the evidence base of public health.

When researchers approach the LHD to engage in research activities that benefit the health of the community:

- Identify appropriate populations, geographic areas, and partners;
- Work with them to actively involve the community in all phases of research;
- Provide data and expertise to support research; and,
- Facilitate their efforts to share research findings with the community, governing bodies, and policymakers.

Share results of research, program evaluations, and best practices with other public health practitioners and academics.
Apply evidence-based programs and best practices where possible.

[1] For the purposes of these standards, an LHD is defined as the governmental public health presence at the local level. It may be a locally governed health department, a branch of the state health department, a state-created district or region, a department governed by and serving a multi-county area, or any other arrangement that has governmental authority and is responsible for public health functions at the local level.

[2] For the purposes of this document, "health disparities" refer to differences in populations' health status that are avoidable and can be changed. These differences can result from social and/or economic conditions, as well as public policy. Examples include situations where city hazardous waste sites are located in poor communities, there is a lack of affordable housing, and there is limited or no access to transportation. These and other factors adversely affect population health.

[3] The standards are framed around the Ten Essential Public Health Services, which have been reworded to more accurately reflect the specific LHD roles and responsibilities related to each category. In addition, these standards are consistent with the National Public Health Performance Standards Program (NPHPSP), serving to specify the role of governmental LHDs while the NPHPSP addresses the public health system as a whole.

[4] This includes those from local health departments, local boards of health, state health departments, and federal public health agencies, as well as county commissioners, mayors, state legislators, and governmental health advisors.

[5] www.naccho.org/accreditation.cfm

[6] NACCHO Resolution 04-05 further describes NACCHO's stance on accreditation.

[7] As defined by the Core Public Health Competencies developed by the Council on Linkages between Academia and Public Health Practice.

Public health professionals and the communities they serve deserve a common set of expectations about local health departments (LHDs). More than 600 governmental public health professionals and local and state officials representing 30 different states contributed to this definition, which will be a living document.

By describing the functions of LHDs, the definition will help citizens and residents understand what they can reasonably expect from governmental public health in their communities. The definition also will be useful to elected officials, who need to understand what LHDs do and how to hold them accountable. And, the definition will aid LHDs in obtaining their fair share of resources.

NACCHO's first step is education and communication about the definition with LHDs, local boards of health, state health departments, federal public health agencies, and local and state elected officials. Metrics will be developed to allow LHDs to measure their progress in achieving the standards.

NACCHO will also gather examples of how LHDs use the definition. The *Exploring Accreditation* project will examine the use of the standards as the basis for a voluntary national accreditation system for LHDs of all sizes and structures.

LHDs can use the definition and standards to assess local efforts, measure performance, expand functions, enhance activities, and communicate about the role of local public health to their governing bodies, elected officials, and community.

NACCHO has developed a set of three fact sheets describing the role of local public health and a communications toolkit as part of this project. Both the toolkit and the fact sheets are available on NACCHO's Web site (see the following column). We encourage LHDs to download the fact sheets and communications toolkit.

Finally, your experiences with the definition will inform and help shape the implementation phase of this effort. Please submit examples of how LHDs have met the definition (particularly those involving the development of shared capacity and/or resources), applied the tools in the communications toolkit, or otherwise used the definition or related materials.

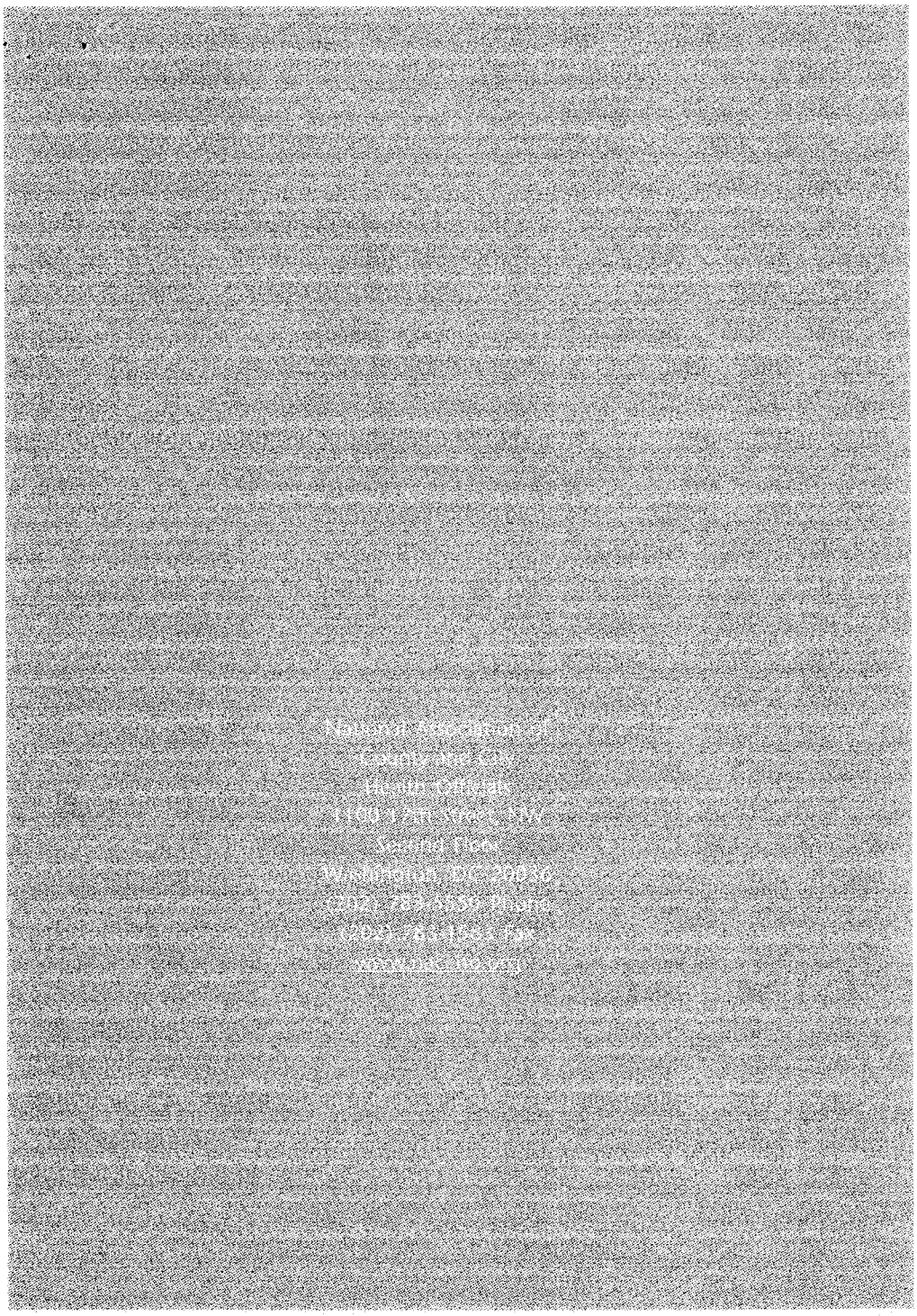
You can find additional materials and submit examples online at:

www.naccho.org/topics/infrastructure/operationaldefinition.cfm

For more information about this project, please contact NACCHO at (202) 783-5550 and ask to speak with the Operational Definition program manager, or e-mail operationaldefinition@naccho.org.

NACCHO thanks the following organizations for their support of the development of the operational definition: the Association of State and Territorial Health Officials, the Association of Maternal and Child Health Programs, the Council of State and Territorial Epidemiologists, the Public Health Informatics Institute, the National Association of County and City Health Officials, the Public Health Foundation, the National Center for Public Health Practice, the Association of Schools of Public Health, the National Center for Health Statistics, the National Institutes of Health, the National Library of Medicine, and the Centers for Disease Control and Prevention.

Funding for this project was provided by the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention (under cooperative agreement U50/CCU302718). The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the sponsors.



Quick Facts – Montana Public Health

Prepared by M. Sare, MSN, RN, LPHO for Granite Co. & Peggy Stevens, RN, LPHO for Mineral Co.

8/18/2008

Operational Definitions: 'Montana metropolitan' (large) = 40,000 or >; Montana urban = 20,001 - 39,999 (medium); rural = 5,001 – 20,000 (small); frontier (extra small/petite?) = 5,000 or less: for county population map (attached) please reference http://www.ceic.commerce.state.mt.us/Demog/estimate/pop/City/estplacepop_bycounty_2007.pdf

- 51 of Montana's 56 counties have Health Resource Service Administration (HRSA) designated Health Professional Shortage Areas (HPSA)
- 53 of Montana's 56 counties hold designations as Medically Underserved Areas (MUA)
- 90% of these counties have high poverty levels (15% or >)
- 39% (22) of Montana's counties have populations of 5000 or less
- 29% (16) of Montana's counties have a population of 10,000 or less
- 16% (9) of Montana's counties have a population of 20,000 or less
- All counties with a population less than 20,000 account for **84%** of Montana's counties
- 5% (45,544) of Montanans live in counties with less than 5000 people
- 13% (122,764) of Montanans live in counties with less than 10,000 people
- 13% (122,255) of Montanans live in counties with less than 20,000
- 31% (290,563) of all Montanans live in counties with less than 20,000
- Top ten counties in highest household income in Montana (2000 Census):
  1. Jefferson County ($48,562)
  2. Stillwater County ($45,870)
  3. **Gallatin County** ($44,600)*
  4. **Lewis and Clark County** ($43,711)*
  5. **Yellowstone County** ($42,971)*
  6. Rosebud County ($42,001)
  7. **Flathead County** ($40,325)*
  8. **Missoula County** ($40,311)*
  9. Cascade County ($38,576)
  10. Broadwater County ($38,246)
- Of the top 10 highest county household incomes – 60% are 'Montana metropolitan', 30% are rural and 10% frontier
- 2000 Census: Counties in Montana poverty rate ranges from a high of 32.4% in Roosevelt County to a low of 9% in Jefferson County
- Top ten counties in terms of poverty rate in Montana & total percent of population living below poverty (2000 Census)
  1. Roosevelt County (32.4 percent)
  2. Big Horn County (29.2)
  3. Blaine County (28.1 percent)
  4. Glacier County (27.3 percent)
  5. Golden Valley County (25.8 percent)

6. Petroleum County (23.2 percent)
7. Rosebud County (22.4 percent)
8. Garfield County (21.5 percent)
9. Judith Basin County (21.1 percent)
10. Chouteau County (20.5 percent)

- 100% of the counties with the highest poverty rates are rural or frontier
- Montana's income level is 27.2 percent lower than the median household income in the United States (2000 Census)
- American Indian and Alaska Native race/ethnicity population holds the highest rate of poverty with 38.4 percent of the 2000 residents living in poverty.
- People aged 5 years/under have the highest percent of people living in poverty in Montana; accounting for 22.6 percent of children under 5 y.o. living in poverty.
- 15 - 20% or > of the population in rural and frontier counties are 65 or older
- Demographics (population 'mixture') play a significant role in the assessment of public health services as opposed to strictly considering population numbers
- PH resources are inefficiently and – in many instances – ineffectively – utilized as a result of the many challenges and barriers facing PH Nursing in frontier (5000 or less) and rural (20,000 or less) communities
- Sweet Grass, Meagher, Golden Valley & Judith Basin have no PH departments
- 18 of Montana's 22 counties with a population of 5000 or less surveyed reported:
  - 63% (13 counties) do not have home health
  - 14% (3) were not available
  - Average county population surveyed 2428.6 (n=15)
  - 28% (6) had secretarial or administrative support
  - Average PH Nurse available hours (including grant and county supported) 28.9 hours per week
  - 100% reported wages below national averages and/or below local hospital pay-scales (one RN with 34 years of experience reported making $10/hour for most of her PH career and only recently began receiving $16/hour – without benefits [this is less than starting RN wages statewide])
  - 100% reported nursing shortages; retention & recruitment disparities
  - 80% (17) reported insufficient time to complete basic PH programs and duties
  - 76% (16) stated that they were unable to bill for any services because of time, ability or other barriers – 100% of these respondents felt that they could generate revenues for their county if they could bill/bill appropriately
  - 40% (9) cited challenges related to distance/time spent in travel (only one county has a county vehicle)
  - 88% (19) did not attend state or regional meetings because of time, money and distance – and – 'no one to answer the phone when I'm gone'
  - 100% stated that they could provide improved PH services and perhaps more in-home services if they had more human resources available – either as another nurse or secretarial support; preferably both
  - 88% (19) stated that they were considering dropping PH programs due to time, human & fiscal constraints

- 16% (3) reported having strong support from their county's Commission
- 9% hold LPNs, 30% ADNs, 60% BSN & 1% MSN (n=12)
- 40% used federal grant monies to hire secretarial help, but did not feel that they were able to provide increased direct service tied to the grant funding
- 100% felt that the immunization program was a financial liability to their county unless all VFC is used (related to billing ability, expenses & challenges)
- 100% felt that their counties maternal-child programs were insufficient; few or no parenting classes; little or no high-risk parenting or childhood interventions
- When asked to rate their ability to meet the PH needs of their county (options: meets all; some; few; none) 57% (10) reported meeting 'some'; 22% (4) reported 'most'; 22% (4) had no PH (n=18)
- When asked to rate the top barriers to quality and quantity of PH/PH programs in their county – the top 4 barriers were: 1. *Money/insufficient budgets* 2. *Absence of qualifies billing personnel* 3. *Lack of qualified nursing personnel and PH nursing time* 4. *Isolation – distance to other services*
- When asked which PH services are lacking/insufficient due to these barriers the responses were: MCH, teen pregnancy prevention/education, STD surveillance and education, family planning, breast feeding, high risk infant follow-up, diabetes education and follow-up, stroke prevention, better epidemiology, home visiting, case and care management, alcohol and drug prevention, school nursing and/or improved partnerships, better collaboration with other HC agencies, better health education and disease prevention & hospice. These were some of the services that the LHJ felt were needed, but were not provided because of the aforementioned barriers to PH care.

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  1. Jefferson County ($48,562)
  2. Stillwater County ($45,870)
  3. **Gallatin County** ($44,600)*
  4. **Lewis and Clark County** ($43,711)*
  5. **Yellowstone County** ($42,971)*
  6. Rosebud County ($42,001)
  7. **Flathead County** ($40,325)*
  8. **Missoula County** ($40,311)*
  9. Cascade County ($38,576)
  10. Broadwater County ($38,246)
- Of the top 10 highest county household incomes – 60% are 'Montana metropolitan', 30% are rural and 10% frontier
- 2000 Census: Counties in Montana poverty rate ranges from a high of 32.4% in Roosevelt County to a low of 9% in Jefferson County
- Top ten counties in terms of poverty rate in Montana & total percent of population living below poverty (2000 Census)
  1. Roosevelt County (32.4 percent)
  2. Big Horn County (29.2)
  3. Blaine County (28.1 percent)
  4. Glacier County (27.3 percent)
  5. Golden Valley County (25.8 percent)

6. Petroleum County (23.2 percent)
7. Rosebud County (22.4 percent)
8. Garfield County (21.5 percent)
9. Judith Basin County (21.1 percent)
10. Chouteau County (20.5 percent)

- 100% of the counties with the highest poverty rates are rural or frontier
- Montana's income level is 27.2 percent lower than the median household income in the United States (2000 Census)
- American Indian and Alaska Native race/ethnicity population holds the highest rate of poverty with 38.4 percent of the 2000 residents living in poverty.
- People aged 5 years/under have the highest percent of people living in poverty in Montana; accounting for 22.6 percent of children under 5 y.o. living in poverty.
- 15 - 20% or > of the population in rural and frontier counties are 65 or older
- Demographics (population 'mixture') play a significant role in the assessment of public health services as opposed to strictly considering population numbers
- PH resources are inefficiently and – in many instances – ineffectively – utilized as a result of the many challenges and barriers facing PH Nursing in frontier (5000 or less) and rural (20,000 or less) communities
- Sweet Grass, Meagher, Golden Valley & Judith Basin have no PH departments
- 18 of Montana's 22 counties with a population of 5000 or less surveyed reported:
    - 63% (13 counties) do not have home health
    - 14% (3) were not available
    - Average county population surveyed 2428.6 (n=15)
    - 28% (6) had secretarial or administrative support
    - Average PH Nurse available hours (including grant and county supported) 28.9 hours per week
    - 100% reported wages below national averages and/or below local hospital pay-scales (one RN with 34 years of experience reported making $10/hour for most of her PH career and only recently began receiving $16/hour – without benefits [this is less than starting RN wages statewide])
    - 100% reported nursing shortages; retention & recruitment disparities
    - 80% (17) reported insufficient time to complete basic PH programs and duties
    - 76% (16) stated that they were unable to bill for any services because of time, ability or other barriers – 100% of these respondents felt that they could generate revenues for their county if they could bill/bill appropriately
    - 40% (9) cited challenges related to distance/time spent in travel (only one county has a county vehicle)
    - 88% (19) did not attend state or regional meetings because of time, money and distance – and – 'no one to answer the phone when I'm gone'
    - 100% stated that they could provide improved PH services and perhaps more in-home services if they had more human resources available – either as another nurse or secretarial support; preferably both
    - 88% (19) stated that they were considering dropping PH programs due to time, human & fiscal constraints

- 16% (3) reported having strong support from their county's Commission
- 9% hold LPNs, 30% ADNs, 60% BSN & 1% MSN (n=12)
- 40% used federal grant monies to hire secretarial help, but did not feel that they were able to provide increased direct service tied to the grant funding
- 100% felt that the immunization program was a financial liability to their county unless all VFC is used (related to billing ability, expenses & challenges)
- 100% felt that their counties maternal-child programs were insufficient; few or no parenting classes; little or no high-risk parenting or childhood interventions
- When asked to rate their ability to meet the PH needs of their county (options: meets all; some; few; none) 57% (10) reported meeting 'some'; 22% (4) reported 'most'; 22% (4) had no PH (n=18)
- When asked to rate the top barriers to quality and quantity of PH/PH programs in their county – the top 4 barriers were: 1. *Money/insufficient budgets* 2. *Absence of qualifies billing personnel* 3. *Lack of qualified nursing personnel and PH nursing time* 4. *Isolation – distance to other services*
- When asked which PH services are lacking/insufficient due to these barriers the responses were: MCH, teen pregnancy prevention/education, STD surveillance and education, family planning, breast feeding, high risk infant follow-up, diabetes education and follow-up, stroke prevention, better epidemiology, home visiting, case and care management, alcohol and drug prevention, school nursing and/or improved partnerships, better collaboration with other HC agencies, better health education and disease prevention & hospice. These were some of the services that the LHJ felt were needed, but were not provided because of the aforementioned barriers to PH care.

The '10 Essentials' of Public Health Service
PH Version and the Plain English Version - 2009

PH Version	Plain English Version
1]. Monitor health status to identify community health problems	What's going on in my community? How healthy are we? Are we ready to respond to health problems or threats in my county?
2]. Diagnose and investigate health problems and health hazards in the community	How quickly do we find out about problems? How effective is our response?
3]. Inform, educate, and empower people about health issues	How well do we keep all segments of our community informed about health issues and develop appropriate education and behavior modification?
4]. Mobilize community partnerships to identify and solve health problem	How well do we really get people engaged in local health issues?
5]. Develop policies and plans that support individual and community health efforts	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6]. Enforce laws and regulations that protect health and ensure safety	When we enforce health regulations, are we technically competent, fair, and effective – what mechanisms are in-place for enforcement?
7]. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Are people in my community receiving the medical care they need?
8]. Assure a competent public health and personal health care workforce	Do we have a competent public health staff? How can we be sure that our staff stays current, meets standards (competencies), guidelines and ethics of professional PH practice?
9].Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Are we doing any good? Are we doing things right? Are we doing the right things?
10]. Research for new insights and innovative solutions to health problems	Are we discovering and using new ways to get the job done and improve outcomes?

To: Representative Gordon Hendricks
Representative Dan Villa

From: Stephanie Nelson RN, MSN
Health Officer

Date: February 2, 2008

Re: HB 173 "Sustainable Public Health for all Montanans'"

Please accept this letter in support of HB 173. This bill is about improving public health services in an accountable and responsible manner. Over the last 10 years a tremendous amount of work has been done to better understand the essential functions of public health agencies and to create standards for accountability of service. The Functional Operational Definition of a Local Health Department is one example and provides a blueprint for what and how tax dollars should be supporting using these standards.

HB 173 will support the application of these standards in Montana in a limited manner. The lessons learned from this project will be very valuable to policy makers in a rural/frontier state for future decisions related to public health. For these reasons I support HB 173.

MISSOULA COUNTY

Missoula City-County Health Department
Health Services
301 W. Alder
Missoula, MT 59802-4123

(406) 258-4750 FAX # (406) 258-4913

March 30, 2009

The Honorable Roy Brown, Chairman
Public Health, Welfare, and Safety Committee
Montana Senate
P.O. Box 200400
Helena, MT 59620-0400

RE: HB 173 Sustainable Public Health for All Montanans

Dear Chairman Brown and members of the Public Health, Welfare, and Safety Committee:

On behalf of the Missoula City-County Health Department, I urge your favorable consideration of HB 173 – Sustainable Public Health for All Montanans. Montana is a vast and beautiful state and all of us deserve access to health and well being. Our local health jurisdictions should be able to protect us from health threats, the everyday and the exceptional. They should provide immunizations, education in health promotion and protection for our water and air. However, all are not equal. Our Public Health system lacks direction because there is no standardization of practice or infrastructure for health jurisdictions across our state. In other words, a health jurisdiction in the northeastern part of the state may have one Public Health Nurse, no support staff, and little training, another of equal size may have a Public Health Nurse, a half time support staff, an office, a regional Sanitarian and plenty of training and understanding about what it means to provide public health. The delivery of services in a 'single person' operation becomes person dependent, which means when that person retires, and soon many public health work force people *will be* retiring, the entire program is lost. The average age of public health workers is approaching 50 in many parts of the country.

In 2007, the Montana Public Health Law Modernization Act was passed, which set the foundation for standardizing the functions for local health jurisdictions. If health were a house, think of public health as the foundation. We should be able to expect that our health department will protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to excellent health. The National Association of County & City Health Officials (NACCHO) has developed an *Operational Definition* of what the role and function of a local health department should be. There are 10 Essential Functions, encompassing verbs such as: understand, investigate, prevent, lead, collaborate, monitor, reduce.

implement, educate and coordinate. In other words, every health department should be able to say, "We've got your back!"

HB 173 can make that happen. This pilot project in 8 jurisdictions will adopt NACCHO's *Operational Definition* and utilize the *Self Assessment Tool* to determine the current functions provided and what is needed. Public Health Nurses (PHNs) are poised to lead in this endeavor; they are vested in communities, practice prevention, and their community members trust and depend on them.

Montana is unique and we are an independent lot, but we should remember that all Montanans deserve to have access and protection to maintain our health and well being. Thank you for your consideration of HB 173. We look forward to working with you on this and other important public health matters. If you have further questions, please don't hesitate to contact me at serstadj@co.missoula.mt.us or 258-4986.

Best regards,

Julie A. Serstad

Julie A. Serstad, RN, BSN, MSN
Health Services Director

Cc: Senate Public Health, Welfare and Safety Committee

March 30, 2009

Dear Chairman Brown and Senators of the Public Health, Welfare and Safety Committee;

We would like to introduce the tenets of **HB 173** - 'Sustainable Public Health for All Montanans';

Co-Sponsored by Representatives G. Hendrick (R) and D. Villa (D)

Purpose: There are three levels of Public Health in every state: Governance (such as Boards of Health), Systems (such as our MT DPHHS) and local. This bill seeks to improve and strengthen ***local*** Public Health (PH). **HB173 - Appropriation for rural Montana healthcare delivery assistance pilot project** (*Sustainable Public Health for All Montana)* is a grass-roots effort that seeks to create a 2 year pilot program, administered by DPHHS, involving 8 Local Public Health Jurisdictions (LPHJ) of varying size (with at least one tribal), to:

- Determine what Local Health Departments (LHD) need in order to perform essential public health functions (as defined by the *National Association of City and County Health Officials* [NACCHO] and national standards from the *Centers for Disease Control* [CDC] and *Public Health Accreditation Board* [PHAB])

- Montana has not legislatively adopted a standard for Local Health Departments that defines what a 'functional health department' looks like across the state. HB 173 will support 8 counties to pilot the '*Operational Definition of a Functional Health Department*' from NACCHO – and utilize the NACCHO Assessment Tool

At the completion of the 2 year project the 8 counties, the PH Improvement Task Force and DPHHS will evaluate the discovered strengths, weaknesses and needs necessary to implement an 'Operational Definition of a Functional ***Montana*** Health Department' statewide.

(The PH Improvement Task Force will direct the progress and deliverables)

Current Situation: PH saves money by preventing disease and improving access to care. Local PH assures healthcare services for their population, assesses community health, develops policy to improve health, provides measures to protect communities from health threats and enforces PH law. Many of Montana's Local Health Jurisdictions (LHJ) (Local Health Departments) lack standardization of basic functional practice; fundamental practice guidelines, based on evidenced based practice such as the '*10 Essentials*', the American Nurse's Association's *Standards and Scope of Practice for Public Health* and CDC's *National Public Health Performance Standards* can not consistently be implemented at the local level because of this lack of understanding,

continuous change in public leadership, shifting county budgets and miss-understandings about PH practice – there is no statewide operational definition of a functional local health department . There is no consistent model of PH functions across the state; large jurisdictions have been better able to create a functional sustainability, but medium, small, and frontier LHJ struggle daily to maintain a competent workforce, attempt to complete excessive workloads with little or no support staff and are engaged in an ongoing exertion to justify their work to BOH and Commissions that lack healthcare expertise.

Necessity of policy change: Montana does not have a sustainable model of ***local*** PH, but the need is great:

- Montana is a unique state where 84% of all counties are small or frontier with populations of 20,000 or less
- 51 of Montana's 56 counties are designated as Health Professional Shortage Areas
- 53 of Montana's 56 counties are designated as Medically Underserved Areas
- 90% of these counties have poverty levels of 15% or greater
- There is a LHD in all but four of Montana's counties
- In some counties this is the only medical service available in a 60+/- mile radius
- With an economy and health care system that is fractured and segmented and long distances to medical centers people living in these communities depend on their LHD for essential health services
- Targeting prevention and maintenance health care are the best ways to create a functional and sustainable health care system; beginning with PHN and LHD that are already established and vested in the community
- PH is poised to address the health care disparities in Montana and is charged with improving access to health care for all Montanans. PH services are cost effective and efficient
- Local PH is supported by county mill levies or federal grant monies. LHJ are supported by as much as 50% federal dollars. If and when these grants go away or are decreased, local PH will face even greater sustainability challenges
- The majority of Montana's small and frontier LHJ are *unable* to bill for services (workload, expertise, Commission support)
- Basic PH services are inequitable across Montana's county lines

Benefits of HB 173 Sustainable Public Health for All Montana: This bill serves **five** cardinal purposes:

1]. **Sustainable** (financial and process) support for all Montana PH departments – regardless of size or economy

2]. **Standardization of PH practice** across the state based on population assessment (basic services that all citizens can expect; record keeping and documentation, processes and quality initiatives to support practice; creation of a PH system where there is no need for fundamental practices to be re-designed county-by-county – currently a tremendous human resource waste = financial waste)

3]. **Improved PH** for all Montanans

4]. **Alignment** with system, governance and LPHJ standards for accreditation: All Montanans deserve the same standards of excellence in PH practice regardless of county size or economy

5]. **Support** for a *vital Montana healthcare workforce*: Public Health

Key Provisions of HB 173:

- The pilot project will assess the challenges and barriers to creating a sustainable model for local PH – regardless of population
- Develop strategies to address discovered challenges and barriers
- Strengthen a vital Montana workforce
- Strengthen fundamental healthcare infrastructure statewide
- Prepare the state's local PH workforce for PH accreditation and the achievement of PH competencies
- Create a sustainable model of local PH for Montana
- Prevent, promote, protect and assist *All Montanans* to live well
- Create an operational definition for Montana local health departments to be used as a guide for LHJ and local Commissions and BOH

*The most important thing is to support a sustainable model of public health for all Montanans; the end result is consistency in public health to **assess, set policy**, and **assure** for **improved health** for Montana's families and communities.*

HB 173: 'Sustainable Public Health for all Montana'

HB 173 is supported by the Montana Public Health Association (MPHA) and the Association of Montana Public Health Officials (AMPHO)….and importantly – by Public Health Nurses and the PH workforce in your community.

AMPHO Public Health

Respectfully submitted by,

Michele Sare, MSN, RN – Granite County, Peggy Stevens, BSN, RN – Mineral County and

Julie Serstad, MSN, RN – Missoula City-County